Mother and Baby Facilities in England

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It is now common practice in many hospitals to admit psychiatrically ill mothers along with their babies. Main[1] first admitted a mother with her child in 1948, and started to admit puerperal cases in 1955. Since those days, there has been a piecemeal development of mother and baby facilities throughout the country. Service developments have usually been the result of local interest rather than central planning and motivated by the belief that such a service adds to the quality of care. We were aware that our hospital was not offering such a service and so we decided to look at what occurred elsewhere to help in our planning. We devised a questionnaire and sent this to 42 district medical officers in England and personally visited the mother and baby units at Park Prewett and Fairmile Hospitals. We received 29 replies to our questionnaire, a 69 per cent response rate. Most of these had been completed by an involved clinician or senior nurse and several expressed a wish to be informed of the findings.

The first question asked was the size of the district. In our sample this ranged from Lancaster Health Authority with a population of 123,000, to Leicestershire Health Authority with a population of 860,000. The mean size was 288,000, but some districts, e.g. Gloucester Health Authority, were providing a mother and baby service to other districts. We then asked whether any facility was available to admit the mothers along with their babies. Six of the districts had no such service themselves, two mentioning that they used one nearby. Leicestershire, which had the largest population of the sample, currently provide no service, but said that a two-bedded unit was planned. There was enormous variety in the services offered, but they could be crudely divided into two groups:

(a) *Specialised unit*

There were six hospitals that had a mother and baby unit. The smallest of these was at Fairmile Hospital. This provides a separate unit within an acute psychiatric admission ward for up to two mothers with their babies, provided that these babies were less than four months old. It only accepts the most disturbed mothers, the less ill ones being intensively supported at home. The largest unit was at Barrow Hospital in the Bristol and Weston Health Authority with a catchment population of 900,000. This has a separate villa-type unit for up to 14 mothers. They accept a wider range of disturbance and babies up to the age of two. Park Prewett Hospital, in the Basingstoke and North Hampshire Health Authority, provides six beds for mothers with their babies up to the age of three. They accept referrals from a very wide area and it is not possible to give their exact catchment population. Unlike Fairmile, they will not generally accept the most disturbed mothers into the unit.

(b) *Mother and baby beds on an acute psychiatric unit*

Seventeen hospitals were of this type. They ranged from clearly well thought-through services to ad hoc usage of acute general adult psychiatric beds. This service was most frequently offered by the hospitals with smaller catchment populations where the more formal units did not seem to be viable. Many of these respondents commented that their arrangements were not satisfactory.

There were 16 replies which gave sufficient information to work out the number of beds required per unit of population. The mean number of beds required was one per 112,437, but there was a wide range with Aylesbury Health Authority requiring one bed per 32,500 population whereas Exeter Health Authority required only one bed per 297,000 population. Both of these respondents felt their bed numbers were adequate. The length of stay also varied greatly from Northampton Health Authority with a mean length of stay of two weeks to Herefordshire Health Authority with a mean length of stay of two months.

We asked questions about the nurse staffing ratio required, compared to acute general adult psychiatric patients, and if especially qualified staff were necessary. Six felt that a higher nursing ratio was necessary for these patients but the others did not feel this to be necessary. Only four had especially qualified staff and these tended to be in the larger units. However the largest unit at Barrow Hospital does not employ such staff and said that they felt that the absence of nursery nurses encouraged the patients to 'mother' their children.

The final question invited any other comments. Several of the respondents mentioned the value of good liaison with the obstetricians and paediatricians. Others spoke of the value of encouraging links with health visitors. The Countess of Chester Hospital places its babies in the hospital crèche. Some spoke of the need for self-locking doors to prevent the possibility of other disturbed patients on the ward harming the babies. Airedale General Hospital ingeniously provide a separate nursery when required, by adapting single room accommodation. The mother and baby are housed in separate adjacent single rooms and a full picture window has been installed between them. This is simply blocked when not required.

Conclusions

We found that in our sample of health districts in England, an enormous variety of services was available. From the replies, it seemed that those districts offering specialised units were the most satisfied. In order to justify a specialised unit, however, it is probably necessary to have a catchment population of approximately 500,000. Much of the advice we received was contradictory, with some units advocating a policy of admission for patient groups

excluded by other units. The differing admission criteria must certainly account for some of the variation in admission rates and length of patient stay.

We decided that for our catchment population of approximately 190,000, a specialised unit would not be appropriate and we were not impressed by the solution of placing the occasional mother and baby on an acute general adult psychiatric ward. It seemed to us that it should be possible to avoid many admissions by providing intensive support at home, and we feel that this could most efficiently be provided by a further development of our community nursing service. We will, however, also need to explore, with neighbouring districts, the possibility of providing a joint mother and baby unit for those women who still require admission.

REFERENCE

[1]MAIN, T. F. (1958) Mothers with children in psychiatric hospital. *The Lancet, ii*, 845–847.

The Problems of Tracing

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The importance of tracing technique and persistence was stressed by Sims.[1] Long-term follow-up studies help to complete the clinical picture, a phrase used by Morris.[2] They also help to clarify such issues as the effectiveness of treatment methods and changes in the socio-demographic status of patients. Unless a high percentage of the follow-up group is effectively traced, then the results of a long-term follow-up study must be suspect.

In this paper we hope to outline the tracing strategy we used in a recent follow-up study of male alcoholics who were admitted to our hospital 20 years ago.[3] We feel this information may have some value for others engaged in this type of research. Also, we have included some of the unusual situations we encountered. Lastly, we hope to comment on some of the ethical issues involved in this type of study.

The study

St John of God Hospital is a 200-bed private psychiatric hospital in the south side of Dublin. The patients were exclusively male until 1968. The hospital deals with all types of psychiatric disorder and is regarded as having a special interest in the treatment of alcoholism.

The study group comprised first admissions to the hospital, in 1964, with a diagnosis of alcoholism. There was no specified catchment area. The cohort numbered 133. The age range was from 25 to 72 and the majority came from socio-economic groups 1,2 and 3.

Changes of address, as far as possible, were noted using hospital charts and telephone directories. A letter was sent to each subject introducing ourselves and the project. We enclosed a stamped-addressed envelope to facilitate the return of the acceptance form. This form had a space for changes of address where applicable.

We attempted to protect confidentiality by firstly keeping the research team to a minimum, that is two. Secondly, all forms with confidential information had a reference number only. The key to these numbers was available to the research team only. In the following tracing methods we attempted to restrict information divulged to the various contacts to a minimum.

The following sequence was employed for non-responders:

1. Telephone calls were made using any of the telephone numbers available to us from the original charts or from new telephone directories. This sometimes meant that our initial contact was with a relation or a friend who accompanied the patient at the time of admission.
2. If contact was still not effected we then contacted the Gardai (police) of the area for which we had an address for the subject. They were asked if they knew if the subject still lived at the last address we had, and to check the register of electors for the area if they did not know.
3. We called at the last address we had for the subjects still not traced from the Dublin area. (It would have been impractical for us to follow this course for the whole country.) We interviewed the current occupants about the subject and his whereabouts. If this did not help then we asked the current occupants for several houses on either side of the original house for similar information.
4. The consular section of the Department of Foreign Affairs was contacted about subjects who were from abroad or had emigrated during the follow-up period.
5. The death certification offices and coroners offices in relevant areas were contacted. This was to obtain death certificates for those we knew to be dead, but also to try to determine if subjects still untraced were in fact dead.

TABLE I
The results of tracing strategies (cohort numbered 133)

Method	Results
Initial letter	46(34.6%)
Phone calls	31(23.3%)
Gardai (police)	5(3.8%)
House calls	3(2.3%)
Other sources	9(6.7%)
Total	94(70.7%)

Of the original group of 133, we successfully traced 94 (70.7 per cent). Of these, 53 were dead at the time of follow-up; the remaining 41 completed our questionnaire. We discuss the mortality data and the other outcome information elsewhere.[3] Forty-five (33.8 per

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